DUR Board Meeting Minutes
Draft

Name of Meeting	Drug Utilization Review Board
Date of Meeting	Thursday, May 14, 2009
Length of Meeting	2:10 PM – 3:25 PM
Location of Meeting	DMAS Board Room 13th Floor

Members Present:
Geneva Briggs, PharmD
Bill Rock, PharmD
Avtar Dhillon, MD
Sandra Dawson, R.Ph, MSHA
Jamie Haight, R.Ph
Renita Driver, PharmD
Cynthia Fagan, FNP

(Not Present: Jonathan Evans, MD, MPH, Michele Thomas, PharmD, Randy Ferrance, MD, Jane Settle, NP)

DMAS Attendees:
Bryan Tomlinson, Health Care Services Division Director
Rachel Cain, PharmD
Tyrone Wall, Compliance Specialist
Scott Cannady, Senior Health Policy Analyst

Contractor: Donna Johnson, R.Ph, First Health Services Corporation

Visitors:
Judy Jenkins, BMS
Richard Grossman, Vectre
Sandra Davis, NeighborCare
Cindy Snyder, GSK
Jenny Vithoulkas, BIPI

Call to Order and Introductions

Chair Geneva Briggs called the meeting to order. Dr. Briggs suggested the Board start with those agenda items that did not require a vote until a quorum arrived. Full quorum arrived before discussion of new drugs.

Potential RetroDUR Review Topics

40 mg daily of Simvastatin in combination with amiodarone.

Therapeutic duplication: More than one muscle relaxers

COPD overutilization of short acting beta agonists

COPD- appropriate management of exacerbations

Nonadherence with maintenance medications, continued
Additional classes might include:
- Anticonvulsants
- Inhaled corticosteroids
- Diabetic medications

Ad hoc Reports

Board reviewed Ad hoc reports for Omnaris (nasal steroids) duration of use in children, narcotic use in patients without a diagnosis of cancer, percentage of all patients on behavioral health medications for service period 1/1/2008 to 12/31/2008 and children taking atypical antipsychotics for service period 9/1/2008 to 2/28/2008.

Behavioral Health Pharmacy Program/CNS

The Board reviewed Children Summary Report from CNS and compared to the reports from First Health. The numbers on the reports from the two sources were similar. The board was asked to look specifically at the Quality Indicator "Use of 5 or More Psychotropics During a 90 Day Period (under 18 years) which had claims for 287 children.

New Drugs

Ms. Johnson presented criteria for the new drugs: Dexlansoprazole, Fenofibric acid, Granisetron transdermal system, Palonosetron, Silodosin, Fesoterodine fumarate and Febuxostat. The Board approved the criteria with the following recommendations:

Dexlansoprazole criteria were approved with a motion by the Board
Fenofibric acid criteria were approved with a motion by the Board
Granisetron transdermal system criteria were approved with a motion by the Board
Palonosetron criteria were approved with a motion by the Board
Silodosin criteria were approved with a motion by the Board
Fesoterodine fumarate criteria were approved with a motion by the Board
Febuxostat criteria were approved with a motion by the Board

RetroDUR Review Reports July 2008 through March 2009

Use of Beta Agonists without an Inhaled Corticosteroid in Patients with Asthma - July 2008

Profiles were reviewed of patients with a diagnosis of asthma who were chronically using a beta agonist inhaler and not using an ICS. If the patient only seemed to be using a SABA occasionally an intervention letter were not sent to the prescriber as they may be using it for EIB. In addition. If the patient was on any form of anti-inflammatory medication other than and ICS, such as leukotriene receptor antagonists, theophylline or cromolyn. While these agents are not the preferred treatments, they are alternatives to ICSs. Furthermore, if the patient also had a diagnosis of COPD or emphysema as inhaled corticosteroids are not recommended unless the patient has stable COPD.

Overall, the asthma patients in this review are being appropriately treated with some form of anti-inflammatory medication. Only 41 letters were sent to prescribers informing them of the potential need for anti-inflammatory medication in their patient. Some of these patients had received an anti-inflammatory in the past and were no longer taking it. These patients may need further counseling for their non-adherence to therapy and the need to control the inflammation.

There were also re-review profiles for the October 2007 Beers Criteria review. These profiles were for patients whose prescribers received letters regarding the inappropriate use of benzodiazepines, barbiturates and certain over-the-counter (OTC) medications in older adults. These medications are still covered by Medicaid but not by Medicare Part D. Of the 158 re-review profiles, 65 (41%) showed no change in therapy while 93 (59%) showed that their therapy had been discontinued.

Polypharmacy - August 2008

Since the polypharmacy review was incorporated into the existing RetroDUR program in August 2005, approximately 10,000 patient medication profiles have been reviewed and a total of 1,032 (10%) intervention letters have been sent to prescribers. The overall prescriber response rate through the March 2008 review rose 27% with 60% of these prescribers responding that they find the information useful and plan to monitor alter or discontinue the treatment regimen.

There were also re-reviews this month for the November 2007 polypharmacy review. A total of 102 letters for 34 patients were sent to prescribers informing them of the potential risk to their patients. Of these original patients, only 2 show no change in therapy.

Medication Adherence: ACE Inhibitors and Beta Blockers - September and October 2008

ACE Inhibitors - September

According to a survey commissioned by the National Community Pharmacists Association, 3 out of every 4 patients in the United States do not always take their medication as prescribed. Lack of medication adherence is a significant problem which can lead to poor clinical outcomes. Improving patient adherence will improve health status and reduce health care costs.[1] Given these findings, the DUR Board undertook an initiative to identify patients who do not regularly refill their medication.

There are several ways to evaluate adherence but the Medication Possession Ratio (MPR) is one of the simplest. The MPR is defined as the sum of all days of a particular drug's days supply divided by the total number of days in the review period. For example, out of a 180 day review period, the patient's total days supply of a given medication is 150 days making the MPR is 0.83 (83%). This formula can be used to evaluate adherence in the major classes of maintenance medications such as ACE inhibitors.

September's review focused on non-adherence with ACE inhibitor therapy. Patients taking an ACE inhibitor during the 6-month period from March 2008 through August 2008 were identified and an MPR was determined. A threshold MPR of 0.80 was used to measure adherence. Using the MPR has some limitations such as it includes those persons who started their medication late in the review period or those persons who came in and out of the fee-for-service program. Also, staff are dependent on the days supply entered by the dispensing pharmacist on the claim for an accurate determination of adherence. The DUR review panel was instructed to take these factors into account as they evaluated the patient profiles and to eliminate any false positive results from our interventions.

One thousand patient medication profiles were reviewed using the process described above. Seventy-five (75) intervention letters were sent to prescribers to alert them to the possibility that their patients may not be adhering to their prescribed treatment plan.

There were also re-review profiles for the December 2007 review of patients with a diagnosis of atrial fibrillation and no evidence of antithrombic therapy. In the original review, 62 letters were sent to remind prescribers of the treatment guidelines and the potential risk to their patients. Of the prescribers that responded to the intervention, 11 replied that the treatment approach was necessary for their patients and 3 replied that they will monitor their patients. The remaining prescribers either did not respond or were not the appropriate prescriber for the patient.

Beta Blockers - October 2008

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[1] *Enhancing Prescription Medicine Adherence: A National Action Plan,* National Council on Patient Information and Education, August 2007 (http://www.talkaboutrx.org/documents/enhancing_prescription_medicine_adherence.pdf).

October's review focused on non-adherence with beta blocker therapy. Patients taking a beta blocker during the 6-month period from April 2008 through September 2008 were identified and an MPR was determined. A threshold MPR of 0.80 was used to measure adherence. Using the MPR has some limitations such as it includes those persons who started their medication late in the review period or those persons who came in and out of the fee-for-service program. The DUR review panel was instructed to take these factors into account as they evaluated the patient profiles and to eliminate any false positive results from our interventions.

One thousand patient medication profiles were reviewed using the process described above. A total of 130 intervention letters were sent to prescribers to alert them to the possibility that their patients may not be adhering to their prescribed treatment plan.

There were also 42 re-review profiles for the January 2008 review of antibiotics used to empirically treat upper respiratory infections. Of the profiles reviewed, 35 showed the discontinuation of antibiotic drug therapy while 7 profiles showed the continued use of antibiotics in these patients. This review was purely to inform the prescribers of the CDC's National Campaign[2] to reduce the rate of antibiotic resistance. The patients who continued to receive antibiotic therapy may have identified bacterial infections that require antibiotic therapy or this could be another infection that is receiving antibiotic treatment. No additional letters were sent to prescribers notifying them of the continued existence of the original issue.

Beers Criteria Review - November 2008

The 2003 session of the Virginia General Assembly passed legislation requiring the Department of Medical Assistance Services to review its elderly long-term care enrollees for any inappropriate use of medications as defined by Dr. Mark Beers.[3] Dr. Beers has published several articles describing the inappropriate use of various medications in older adults. The Beers criteria were presented to the VA Medicaid DUR Board for review and approval. The Board approved the criteria and agreed that this review would be performed every 6 months as a retrospective review of 1000 enrollee medication profiles. Additionally, the Board recommended that the review should include all VA Medicaid enrollees 65 years and older, not just those in long-term care facilities.

With the implementation of the Medicare part D pharmacy drug plan, Medicaid is no longer covers the majority of the medications on the Beers List. However, two major classes of drug are excluded by Medicare and are covered by Medicaid. These are the benzodiazepines and barbiturates. Additionally, Medicare Part D does not cover over-the-counter (OTC) medications. OTC medications such as antihistamines and decongestants are included in the Beers criteria. Therefore, the focus of this review is on the Beers criteria for these types of medications. One thousand medication profiles were generated for all

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[2] Centers for disease control and prevention. Get smart: know when antibiotics work. http://www.cdc.gov/drugresistance/community/healthcare_provider.htm. Accessed January 16, 2008.

[3] Fick DM, Cooper JW, et al. Updating the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. *Arch Intern Med.* 2003;163:2716-2724.

enrollees 65 years and older who met any of the Beers criteria for benzodiazepines, barbiturates or OTCs.

Of particular interest in this review was that 37% of the criteria interventions involved the use of benzodiazepines in doses that exceed the recommended maximum dose in older adults; 19% involved the use of benzodiazepines that are inappropriate to use in older adults at any dosage; 8% of the interventions involved the use of benzodiazepines or barbiturates that are not recommended in patients with certain medical conditions and 8% involved the inappropriate use of the over-the-counter antihistamine, diphenhydramine, as a sedative-hypnotic. Overall, the inappropriate use of these medications can lead to prolonged sedation and an increased incidence of falls and fractures in the older adult patient.

There were a total of 167 letters sent to prescribers whose patients are receiving medications or dosages that are potentially inappropriate for them. If a prescriber responded to a previous letter that the treatment was clinically appropriate, no letter was sent for this review. Staff must assume that the prescriber has evaluated the risks versus the benefits of using one of these medications in their older patient.

There were also 188 re-review profiles for the February 2008 review of the FDA warning regarding the risk of severe musculoskeletal pain associated with bisphosphonates.[4] Of the original 257 patients, 188 remain on their bisphosphonate therapy. The majority (88%) of the prescribers that replied to the intervention indicated that the therapy was needed and they would monitor their patients for adverse reactions. No additional letters were sent to prescribers notifying them of the continued existence of the original issue.

Polypharmacy - December 2008

The profiles of patients meeting polypharmacy criteria were reviewed. Care was taken not to letter when the patients had obvious diseases or combination of diseases that would easily require more than nine prescriptions each month and possibly several doctors. Staff looked for patients who are chronically at risk for drug interactions, therapeutic duplication, or those who may be doctor or pharmacy shopping. A total of 110 letters were sent to prescribers informing them of their patients' polypharmacy and the potential risks.

Since the polypharmacy review was incorporated into the existing RetroDUR program in August 2005, approximately 11000 patient medication profiles have been reviewed and a total of 1170 (10%) intervention letters have been sent to prescribers. The overall prescriber response rate through the July 2008 review rose to 39% with 82% of these prescribers responding that they find the information useful and plan to monitor, alter or discontinue the treatment regimen.

There were also re-reviews this month for the March 2008 polypharmacy review. A total of 42 letters for 18 patients were sent to prescribers informing them of the potential risk to their patients. Of these original patients, only 3 show no change in therapy.

Medication Adherence – Statins, Antiretrovirals and Antiepileptics - January to March 2009

January's review focused on non-adherence with statin therapy to reduce cholesterol levels. Patients taking a statin during the 6-month period from July 2008 through December 2008 were identified and an MPR was determined. A threshold MPR of 0.80 was used to measure adherence. Using the MPR has some limitations such as it includes those persons who started their medication late in the review period or switched to a different statin or those persons who came in and out of the fee-for-service program. Also, staff are dependent on the days supply entered by the dispensing pharmacist on the claim for an accurate determination of adherence. The DUR review panel was instructed to take these factors into account as they evaluated the patient profiles and to eliminate any false positive results from our interventions.

One thousand patient medication profiles were reviewed using the process described above. A total of 88 intervention letters were sent to prescribers to alert them to the possibility that their patients may not be adhering to their prescribed treatment plan.

There were also re-review profiles for the April 2008 Beers Criteria review. These profiles were for patients whose prescribers received letters regarding the inappropriate use of benzodiazepines, barbiturates and certain over-the-counter (OTC) medications in older adults. These medications are still covered by Medicaid but not by Medicare Part D. Of the 124 re-review profiles, 73 (59%) showed no change in therapy while 51 (41%) showed that their therapy had been discontinued.

Statins, Part II - February 2009

February was American Heart Month and there has been much in the news about the importance of controlling cholesterol levels. Since there are so many patients who appear to be non-adherent with their statin therapy, we repeated the review again this month with another set of recipients who are potentially non-compliant with their statin therapy using the medication possession ratio (MPR) approach.

Patients taking a statin during the 6-month period from August 2008 through January 2009 were identified and an MPR was determined. A threshold MPR of 0.80 was used to measure adherence. Using the MPR has some limitations such as it includes those persons who started their medication late in the review period or switched to a different statin or those persons who came in and out of the fee-for-service program. Also, we are dependent on the days supply entered by the dispensing pharmacist on the claim for an accurate determination of adherence. The DUR review panel was instructed to take these factors into account as they evaluated the patient profiles and to eliminate any false positive results from our interventions.

One thousand patient medication profiles were reviewed using the process described above. A total of 176 intervention letters were sent to prescribers to alert them to the possibility that their patients may not be adhering to their prescribed treatment plan.

There were also re-review profiles for the May 2008 RetroDUR review. Two topics were reviewed for May; (1) diabetic care in mental illness patients and (2) iron supplementation during epoetin therapy. A total of 28 letters were sent to prescribers of mental illness patients with diabetes and no evidence of diabetic care monitoring; such as routine blood glucose monitoring, foot examinations, eye examinations or lipid panel tests. Of the original patients, 15 show evidence of one or more of these routine monitoring procedures. For the patients receiving epoetin therapy with no iron supplementation, a total of 44 letters were sent to their prescribers explaining the need for adequate iron stores during epoetin therapy for the body to produce red blood cells. Of these original patients only 15 are still taking epoetin. Of the patients on epoetin 8 are now receiving iron supplementation and 7 patients are not receiving iron or having their iron levels tested.

Antiretrovirals and Antiepileptics - March 2009

Reviews of medication adherence with two more classes this month – antiretrovirals and antiepileptics will continue as follows

Adherence to antiretroviral therapy (ART) is a major determinant of survival. Nonadherence can lead to the progression of HIV due to the development of drug resistance by the virus. This can also be a significant public health concern because of the risk of new patients becoming infected with a drug-resistant virus. For optimal success, adherence rates near 100% are needed. However, the average adherence rate in the United States is roughly 70%.[5] For our review, a threshold MPR of 0.95 (95%) was used to measure adherence. Using the MPR has some limitations such as it includes those persons who started their medication late in the review period or switched to a different statin or those persons who came in and out of the fee-for-service program. Reports are dependent on the days supply entered by the dispensing pharmacist on the claim for an accurate determination of adherence. The DUR review panel was instructed to take these factors into account as they evaluated the patient profiles and to eliminate any false positive results from our interventions. Staff reviewed 251 patients on ART therapy. A total of 17 intervention letters were sent to prescribers to alert them that their patients may not be adhering to their prescribed therapy.

Our second area of focus was the issue of nonadherence with antiepileptic drugs (AEDs). Like other chronic diseases, non-adherence to medication in patients with epilepsy leads to higher rates of seizure reoccurrence and increased associated medical costs.[6] Using a threshold MPR of 0.8 we reviewed the profiles of 796 patients with a diagnosed seizure disorder and potential nonadherence to their AEDs. A total of 24 intervention letters were sent to their prescribers to alert them to the potential nonadherence.

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[5] AIDS education and training centers national resource center. Section 3 Antiretroviral therapy. Clinical manual for management of the HIV-infected adult, 2006 ed. Newark, NJ. Available at http://www.aidsetc.org. Last accessed April 7, 2009.

[6] Davis KL, Candrilli SD, Edin HM. Prevalence and cost of nonadherence with antiepileptic drugs in an adult managed care population. *Epilepsia*, 49(3):446-454, 2008.

There were also re-review profiles for the June 2008 RetroDUR review of patients with a diagnosis of asthma who were chronically using a beta agonist inhaler and not using an inhaled corticosteroid (ICS). According to the latest Asthma Management Guidelines from NHBLI, except for the treatment of acute exacerbations or exercise-induced bronchospasm, beta agonists should not be used as monotherapy. Of the original 41 patients that were involved in the intervention, 4 are no longer using a beta agonist inhaler and 2 others are concurrently using a beta agonist inhaler along with an ICS. The remaining 35 patients are still receiving beta agonist therapy but are not on ICS therapy.

Other Business

Next meetings: The Board decided to schedule their quarterly meetings on the third Thursday of March, May, August, and November.

Adjournment: 3:35 P.M.